Instructions for Parents/Guardian

Please complete the attached one page form to begin the process of applying for the Autism Waiver program.

Step 1.
Section 1 requests basic information about your child and family. Personal information will be protected according to HIPPA guidelines**.** Please provide your child's name, date of birth, social security number (or SSN), your name as the parent or guardian, your address, a phone number by which you can be reached, and if applicable a Medicaid Identification Number.

Step 2.
Section 2 includes two components. The first part requires you to indicate with a check mark which Autism screening tool was used in your child's diagnosis. Please check all that apply and if the screening tool is not listed, please specify which tool was used.
The second part is a check list of needed items to accompany this application. Please check next to "Documentation of Autism diagnosis is attached" if you have enclosed diagnosis documentation. Please check the "Signature of licensed Medical Doctor or Ph.D. Psychologists" if a Medical Doctor or Ph.D. Psychologist has read, signed and dated the statement provided at the bottom of section 2.

Step 3.
The form must be completed in its entirety to be eligible.
The fully completed application can be submitted three ways.

1. Faxed to CSS, at 785-296-0557,
2. Hand delivered to your local SRS office to be time/date stamped and faxed to CSS, or
3. Mailed to Docking State Office Building
   Attention: Community Supports & Services
   915 SW Harrison, 9th Floor
   Topeka, KS 66612

What Happens Next?

If a child meets the criteria for the HCBS Autism Waiver, the child will receive a letter from the Autism Program Manager informing them they have been placed on the Proposed Waiver Recipient List and their numerical position on the list. When a position on the waiver becomes available the Program Manager will contact the family to offer them the potential position.

Once a child has been referred by the Program Manager for assessment, the Functional Eligibility Specialist has 5 working days to schedule a home visit and complete the functional eligibility assessment to determine if the child meets the established criteria. If the child meets the criteria, the Functional Eligibility Specialist will assist the family in completing the Medicaid application (if necessary) and refer to an Autism Specialist.

The Autism Specialist has 5 working days to contact the family to begin the development of the Individualized Behavioral Plan/Plan of Care.

✶✶✶**PLEASE NOTE: SRS Regional Office must affix time/date stamp immediately upon receipt.** ✶✶✶

Home and Community Based Services
Autism Waiver

The form must be completed in its entirety to be eligible.
The fully completed application can be submitted three ways.

1. Faxed to CSS, at 785-296-0557,
2. Hand delivered to a local SRS office to be time/date stamped and faxed to CSS, or
3. Mailed to Docking State Office Building
   Attention: Community Supports & Services
   915 SW Harrison, 9th Floor
   Topeka, KS 66612

SECTION 1: Child and Family Information

Please provide the following information:

Child's Name: _____

Child's Date of Birth: _____

Child's SSN: _____

Parent/Guardian: _____

Address: _____

Phone Number: _____

Medicaid ID Number (if applicable): _____

SECTION 2: Autism Spectrum Disorder Information

Diagnosis was made with the aid of the following approved Autism screening tool:

__ CARS Childhood Autism Rating Scale
__ GARS Gilliam Autism Rating Scale
__ ADOS Autism Diagnostic Observation Scale
__ ADI Autism Diagnostic Interview-Revised
__ ASDS Asperger Syndrome Diagnostic Scale
__ Other Please Specify _____

Documentation of Autism diagnosis or a signature of a licensed Medical Doctor or Ph.D. Psychologist must be included at the time the application is submitted.
Please indicate with a check mark if any or all of the following is included with this application:

_____ Documentation of Autism diagnosis is attached.

_____ Signature of licensed Medical Doctor or Ph.D. Psychologists

Documentation will be required at the time of eligibility determination.

I have made a diagnosis of an Autism Spectrum Disorder for _____.
Enter Child's Name

_____

Signature of Doctor | Printed Name of Doctor | Date